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Health and Social Security Scrutiny Panel

Women's Health Hearing

Witness: The Minister for Health and Social Services

Wednesday, 30th April 2025

Panel:

Deputy L.M.C. Doublet of St. Saviour (Chair)

Deputy J. Renouf of St. Brelade (Vice-Chair)

Deputy P.M. Bailhache of St. Clement

Deputy L.K.F. Stephenson of St. Mary, St. Ouen and St. Peter

Witnesses:

Deputy T. Binet of St. Saviour, The Minister for Health and Social Services

Deputy A. Howell of St. John, St. Lawrence and Trinity, Assistant Minister for Health and Social Services

Ms. R. Johnson, Director of Health Policy

Ms. S. Evans, General Manager, Medicine

Dr. C. Jenkins, Consultant Anaesthetist

Ms. R. Bullen-Bell, Director of Midwifery and Nursing for Women and Children

Professor E. McVeigh, Consultant Gynaecologist

[12:00]

Deputy L.M.C. Doublet of St. Saviour (Chair):

If everybody is settled I am going to open the hearing, and my name is Deputy Louise Doublet. I am the chair of the Health and Social Security Scrutiny Panel. I am so pleased to welcome all of the members of the public who have attended today. I am really delighted to see such a good turnout. I know there are some medical practitioners in the room as well, so thank you so much for

coming. Welcome to the Ministers and their team as well. We usually hold these hearings in the rather formal Scrutiny rooms within the States Chamber building, so this is a slightly different venue, slightly different format. It is a trial that we are doing to try and increase engagement and so far it seems to have been successful. But please do fill in the feedback cards that you have on your seat there because what we would like to do is reflect on how the hearing has gone. If there are any other things that you think Scrutiny could be doing to make our work more accessible, more interesting, more engaging to you, then please let us know because we will trial other ways of doing that. Today we will be putting questions that have been sent in by members of the public and also questions that we have compiled ourselves among the panel, so thank you to everybody who has sent in questions in advance. We had many, many question areas. We have not been able to fit all of them in, but we have tried to put as many questions from the public as possible into this hearing. Minister, I will ask you in a moment to introduce yourself. Just a couple of notes for the hearing. If you could ensure that you speak up. Can I just check that everybody can hear me where I am at the moment because this is slightly different technology to usual? When you speak you need to press the green button on the little box in front of you there. Has everyone located that and is happy with that? Okay, great.

The Minister for Health and Social Services:

It can only take 4 microphones at once, so somebody has to switch off in order to ...

Deputy L.M.C. Doublet:

So hopefully we will not have 4 people speaking at one time. Thank you. I am going to do a bit more of an introduction than I usually do, just to set the scene for members of the public today. But before I do that, I wanted to thank my officers, who some are sitting on the side of the room there, we have got some behind and around the room. As I said at the beginning, this is a really different setting and lots of additional arrangements have had to be made, and I cannot underestimate how grateful the panel is to our officers for accommodating all of that and really delivering today for the public, so thank you to our officers. The purpose of Scrutiny is to scrutinise the Government's actions and plans and to help the public understand the reason behind policy decisions. We also assess the effectiveness of measures announced and we explore any further improvements and discuss those with Ministers. Our shared goal today is to establish whether the health needs of women and girls are being met with the urgency and priority they deserve. I know that is something that is of great importance to the Ministerial team as well. I am going to ask everybody to do introductions now, and we will start with my panel. If my vice-chair could begin.

Deputy J. Renouf of St. Brelade (Vice-Chair):

Deputy Jonathan Renouf. I am the vice-chair of the panel.

Deputy P.M. Bailhache of St. Clement:

Philip Bailhache. I am a member of the panel. Perhaps I could just say that I have to leave unfortunately just after 1 o'clock, and it will not be as a result of anything that you have said, Miniter.

Deputy L.K.F. Stephenson of St. Mary, St. Ouen and St. Peter:

Deputy Lucy Stephenson, a member of the panel.

Deputy L.M.C. Doublet:

Minister, if you could introduce yourself and your team.

The Minister for Health and Social Services:

I am Deputy Tom Binet, Minister for Health and Social Services.

Assistant Minister for Health and Social Services:

Deputy Andy Howell, Assistant Minister.

Consultant Anaesthetist:

Caroline Jenkins, consultant anaesthetist. I am also the chief of service for the Women's and Children's Care Group.

General Manager, Medicine:

Sarah Evans, I am the general manager for Medicine and also responsible for screening services.

Consultant Gynaecologist:

Enda McVeigh, I am a consultant gynaecologist.

Director of Health Policy:

Ruth Johnson, director of health policy.

Deputy L.M.C. Doublet:

I know that you have some other officers. When they do need to join the table, perhaps at that point they could introduce themselves. I am just going to set some global and historical context for women's health and the reason why we are here today. Throughout history, doctors have considered women's bodies atypical and men's bodies the norm, despite women accounting for half the global population. There have been some policy and social changes, particularly around the 1990s, that have started to turn the tide, but women remain under-represented in research, and sometimes grossly so, and with many negative impacts. Historical bias, policies designed to shield unborn children from exposure to drugs and treatments, concerns about fluctuating hormone levels

confounding study results mean that there are healthcare disparities. Biological sex can play a role in physiological, metabolic, hormonal and even cellular differences that can influence how diseases present and thus the effectiveness of any pharmaceutical interventions. Women, for some pharmaceuticals, have been found to experience adverse effect from medications at twice the rate of men, and this is one of the results of this under-representation in medical studies. We know that for some diseases, the symptoms present differently in women, for example heart disease, and this is not always well-known even among medical practitioners, so women are less likely to receive appropriate prevention and management of diseases. That is the global and historical context, which of course is outside of our control, but that is one that our healthcare system is operating within. I want to take a moment here to thank all of the healthcare professionals that we have in Jersey, because I know that there are many, many, many individuals who are working tirelessly on a daily basis, improving health outcomes and saving lives. The panel are very, very grateful for all of the work that is done. In terms of the Jersey context, we recently had the publication last year of the *Women's Health and Wellbeing Joint Strategic Needs Assessment* report. This, again, I would like to thank the Public Health Department because this brings all of the global and international context into Jersey and has local data in there and lots of information from hundreds of Jersey women who filled in the government survey, and we have used this report as a basis for our questioning to understand where we need to question the Minister. Some of the findings in that report - and if anybody wants a copy of it there are some available - that women live longer than men, but they spend many more years in poor health than men. Only 27 per cent of women in Jersey felt their mental health needs were being met. One in 4 women reported frequent feelings of loneliness. Women reported many barriers to healthcare, including cost, access to appointments and lack of self-referral options. Half of adult women and one-third of girls are overweight or obese, and only 5 per cent of teenage girls meet the recommended daily activity levels. This report should be read, I believe, in conjunction with the Violence Against Women and Girls report. These 2 reports together give a really clear picture of what it is like to be a woman or a girl in Jersey, and I think both reports are real watershed moments for Jersey in understanding women's experiences that hopefully we can all learn from and improve our policies and legislation going forwards. In response to this report, Government have implemented several measures. I believe they have announced the refurbishment and the reopening of Rayner Ward, which I think is happening later this year; a gynaecological services improvement plan; a social prescribing platform; and work on a termination law in response to our amendment. We celebrate the work that the Ministerial team are doing. However, there are still some concerns about the adequacy and the timeliness of these responses. One of the biggest concerns that the panel is hearing from women and from professionals is that the decision to scrap the standalone women's health strategy indicates a lack of long-term commitment. We are also hearing concerns around enduring cultural issues that women face when accessing healthcare, which will need a significant effort to overcome. We are about to start the questions. I wanted to make a remark about men's health because that came up at our quarterly

hearing. We are here today to talk about women's health, and our discussions will be centred around that. However, the panel are aware that there are some issues with men's health as well. We are planning to ask some questions on men's health at our next quarterly public hearing, which will be on 20th May and you are all ... well, possibly not all of you if we are in our usual rooms, but people are welcome to come and join that hearing as well and watch that hearing. Before we start the questions, Ministers, I would like to emphasise that we are very, very tight on time today, and we are always, I think, a bit tight on time, but the sheer volume of areas that we have to cover means that answers really need to be very concise. So new information, the pace at which you are delivering your answers, if you could bear in mind the timings. I do apologise in advance if I need to cut anybody off, because I need to make sure that we can fit in all areas that my panel are going to be asking. Just a note for the audience as well, could everybody check that their mobile phones are turned off, please, and that silence is maintained throughout the hearing? But do feel free to come and go quietly. Minister, given the global and historical context for women's health that I have just outlined, what comments can you make on how this impacts women locally in Jersey?

The Minister for Health and Social Services:

I am conscious of time but I think there is something that I should make clear to everybody here, and I thank everybody for turning up, because it was mentioned on the radio this morning that I was responsible for cancelling the woman's health strategy. That is not a fact. It was cancelled prior to me coming to office. My understanding is there was not a strategy in place. The intention had been to produce a strategy, but it was made plain to the previous Minister for Health and Social Services that there was not sufficient funding to deliver a strategy once it was compiled. As such, I thought that was a sensible decision to take, that it was not worth producing a strategy and paying for it to leave it on the shelf. I inherited that situation and decided to maintain that position, but I wanted to make it clear that the decision not to proceed with it was not my doing, albeit that it was a sensible decision given the funding issues, which I am sure we will touch upon. I have spoken to such length I will ask you to repeat the first question if you would, sorry.

Deputy L.M.C. Doublet:

Yes, so what comment can you make on how the global and historical context impacts women's health here in Jersey?

The Minister for Health and Social Services:

I know that there have been some comments about a misogynistic approach to healthcare and I think that historically, the further back you go, the more that would probably have been the case. I am very, very pleased to see that while there might still be some carryover elements of that, that by and large there are an awful lot more women in senior places in health, and elsewhere for that matter. For example, the new hospital facilities team, 3 of the 4 key players at the top of that are

women. I think we are getting towards the end of that and we are very keen to see a complete end to that.

Deputy L.M.C. Doublet:
What data do you have that demonstrates that the misogyny is ...

The Minister for Health and Social Services:
From my point of view, it is anecdotal. I think it is an acceptance of the whole of history with men dominating everything, and I think that logically runs through virtually every element of society. I am very, very comfortable that there are some very competent women in powerful places in health and I think that is all for the good.

Deputy L.M.C. Doublet:
Do you accept the findings of this report that is authored by Public Health?

The Minister for Health and Social Services:
Absolutely. I do not think there is anything that one could argue with.

Deputy L.M.C. Doublet:
So you understand there is still a problem with misogynistic attitudes in some settings?

The Minister for Health and Social Services:
There are in some settings, yes, and the sooner that can be got rid of the better.

Deputy L.M.C. Doublet:
How do you plan to tackle that?

The Minister for Health and Social Services:
That is cultural and there are an awful lot of things that you do in terms of culture. I have taken the view from a Ministerial point of view - and encourage the team to do the same thing - is to be open and honest about everything however awkward it may be. We are going to have some very awkward conversations about funding and we have to take that on those as well. I think if you have an open culture politically at the top of an organisation that eventually filters through. You indicate there is no place for anybody doing the sort of things that we are talking about here.

Deputy L.M.C. Doublet:
Do you take a gender-sensitive approach to your policy making?

The Minister for Health and Social Services:
I would certainly hope so, yes. I think all the people that I work with, I do not see any evidence that that is not the case.

[12:15]

Deputy L.M.C. Doublet:
So you understand that men and women have different health needs and you take that into account when you are structuring your policies?

The Minister for Health and Social Services:
As I have explained to you, there are a lot of women in my life that are very, very close to me. Some of them are older, like me, and I see a lot of these problems first-hand. You will not find anybody keener than me to make sure those problems are resolved.

Deputy L.M.C. Doublet:
Could you give an example of how you have implemented this recently?

The Minister for Health and Social Services:
No, I cannot handpick anything specific. Just to say that our general approach is one of openness, equality and fairness of treatment, no toleration of misogyny or bullying and that, I like to think, runs throughout all of the work that we do.

Deputy L.M.C. Doublet:
Minister, you mentioned that the women's health policy was planned to be cancelled. Given the public feeling around this and the public feeling in favour of a women's health strategy, have you reconsidered or would you reconsider that?

The Minister for Health and Social Services:
At this point in time I cannot because - I think this is quite well-known - our Health budget was under an enormous amount of pressure. We spent more than was allocated to us last year and I do not mind saying, because we said we would be open and honest, it is likely that that is going to happen again this year. We are under huge pressure. Where I am comfortable is that that we, in deciding not to progress with a strategy, which was unfunded, that we would have some particular focus on what we could do within the means that we had available to us. It is the Women's Political Advisory Group that has been leading on that, under the careful guidance of Deputy Howell. As far as I am concerned, it is for women to identify the things that they think are most important. It is not for me to do that. I would rather listen to women who want to put a list of priorities forward. I will do

everything that I can within the means available to make sure that we exercise all of that as swiftly as we can.

Deputy L.M.C. Doublet:
How much would it cost to produce a strategy?

The Minister for Health and Social Services:
To be honest with you, off the top of my head, I really do not know but I will say this to everybody, I have been in politics 3 years and when I first arrived one policy after another ended up on my desk and it ended up on the shelf, because when I went to people and said: "How are we going to implement ... what is the timing for implementing the strategy?" the answer was: "There is no money."

Deputy L.M.C. Doublet:
Can any of the officers advise how much the strategy would cost to produce?

Deputy J. Renouf:
The microphones I think are only for the cameras unfortunately.

Director of Health Policy:
With regard to the production of the strategy, it would depend entirely on what we set out to achieve at the outset of the strategy, but it broadly ... we have now got the Jersey Strategic Needs Analysis, so we have got a lot of background information and evidence. But I think it would probably ... if I talk about in terms of officer time rather than in terms of money, it would probably take one of my team of policy officers out of their work for about 3 to 4 months.

The Minister for Health and Social Services:
Could I just make a point? Because as head of policy, Ruth could explain a little bit about the pressure that she is under in terms of policy drafting, because (a) there are no more resources to employ policy officers, and you cannot get them for love nor money. We are having a very, very difficult job in defining what priorities we work on, and we are under pressure from all sides. Ruth is under extreme pressure.

Deputy L.M.C. Doublet:
Understood. Thank you. We may come back to this area, but we are going to move on to the next question now.

Deputy J. Renouf:

We know that historically women's health has been treated less seriously, both in research and in terms of some conditions and so on. Is there anything you can point to that you have been doing since you became Minister to tackle any of those issues?

The Minister for Health and Social Services:
I made the point that initially the Women's Advisory Group said they wanted to focus on termination of pregnancy, I.V.F. (in vitro fertilisation) and contraception, and that is the work that has been going on, and that is the work that Ruth has been working on in terms of women's equality.

Deputy J. Renouf:
So in terms of the areas where women have been treated less seriously, there is evidence in here around menopause and things like this, pain management and so on, are those issues being addressed culturally?

The Minister for Health and Social Services:
They are. I think we could probably bring someone in to talk about the work that is ... it is better that we talk ... if you do not mind the specialist advisers to tell us in detail the things that are going on.

Deputy J. Renouf:
I think you will need to speak up.

Consultant Gynaecologist:
So which area would you like to?

Deputy J. Renouf:
There are several issues there to do with pain management, for example, to do with menopause and so on, where people cited that their experiences were not being treated seriously. I wondered whether there have been any efforts to address those cultural issues.

Consultant Gynaecologist:
Menopause, as a good example, I set up and have run the menopause service here for the last 3 years. There is no current waiting list for that clinic. Inside 4 weeks a patient can be seen. But all women will go through menopause at one stage, so my colleagues in primary care are very able to look after that. What I then tend to see in our clinic is the more difficult end of it, where perhaps a woman has had an oestrogen-sensitive cancer, where it might be contra-indicated for H.R.T. (hormone replacement therapy), but there are other ways of doing it whereby there are other issues around that. It is triaging and seeing appropriately, so that we have got an efficient and effective service. For pelvic pain, again, in my 25 years at Oxford, we set up a national service for pelvic

pain, and we have one of the leading researchers and developers in that very complex disorder. It is one of those Venn diagrams of many overlapping potential areas. Like all things in medicine, the key is always a diagnosis. Can I understand why there is that pelvic pain, and is there a learned ability to it as well? Because as a woman gets pain she can then feel more pain and there is a supratentorial effect on it as well. So really complex and needs a multidisciplinary team to manage this.

Deputy J. Renouf:

I get you are addressing the treatment side of it. I was also interested in the cultural side and the experience that women had and, in particular, the experience that they were not treated seriously in some parts of the organisation. I wondered what you were doing at that cultural level within the organisation.

Consultant Gynaecologist:

So the culture can be leading from the front and showing this is how I do it, this is how I run it, this is the pathways we set up, an evidence-based pathway to manage those clinical scenarios true, and then ensure that you have regular teaching with your middle grades and other consultant colleagues on how we do it. But if there is a culture that is affected, it does take time to change it. It is not going to change overnight. But again, I think it is leading, it is asking the public, doing regular surveys, finding out what the issues are. Through our Datix and S.I.s (serious incidents), we can have feedback to intermediary and senior colleagues. So there are processes in place that do this. I firmly believe that we are moving in the right direction with this.

Deputy L.K.F. Stephenson:

I wonder if I could just follow up slightly more specifically on some of the types of things that women would be experiencing over here. Acknowledging that we are a small jurisdiction, we cannot have the best specialists in everything all of the time, do you think we have got effective partnerships in place with other maybe specialist areas where we can link with them, things like endometriosis, for example, comes to mind, and P.C.O.S. (polycystic ovary syndrome), those kind of things?

Consultant Gynaecologist:

So, endometriosis, I was fortunate that I set up the National Centre for Endometriosis in Oxford 25 years ago, and we have developed that and we do significant research in that, which is a polygenic disorder and many things can lead to it. True, I think my consultant colleagues here in Jersey who have maybe come here from the U.K., they can bring those links with them. I can link into the M.D.T. (multidisciplinary team) team in Oxford very easily, with Southampton, with Guy's and Thomas'. So we do have that ability. Polycystic ovarian syndrome, one in 20 women have it, one in 3 women have polycystic ovaries. Again a very common condition that is very well-managed in primary care

and it is only when you get into specific conditions does it need to be managed at a secondary care level. To answer your question, yes, I do believe we have those ties if we need them.

Deputy L.K.F. Stephenson:

The ties may be there on a consultant basis but are there formal established pathways in Jersey so we know, and women who present with those conditions know, they will be looked after, this is what will happen, they will be sent to Southampton if they need it?

Consultant Gynaecologist:

Once they get to our secondary level on to it, yes, those are very clear. It is that there can sometimes be some inertia going from primary care into secondary care, and it is important that we get those pathways pushed down and have regular meetings with our Primary - I do not sit on the Primary Care Board - Care Board, to get that information down, at this stage we should trigger forward. For example, like A.R.U. (Assisted Reproduction Unit), there is now no necessity to go through primary care. You can direct refer into, a very good example, our secondary care level. For recurrent miscarriage, again, that can be a direct referral in because there are certain conditions that women will know their diagnosis before they go to their primary care physician. They know that they cannot get pregnant . They know that they have had 2 miscarriages. So they do not necessarily need to go through that gatekeeping and we can speed up the process and accelerate that. I think those are all positive measures that have happened over the last 2 to 3 years, certainly since I have been here.

Deputy L.M.C. Doublet:

Thank you. I want to pick up on the question about culture change. You said that that was being addressed through your work. Can I ask whether that is through implied leadership and showing a good example? Or is it made visible and explicit? Are there any policies or initiatives that have been initiated, either at a consultant level or a Ministerial level, that say: “Look, there are problems that have been identified and we acknowledge them and let us tackle them?” Any visible?

The Minister for Health and Social Services:

I am happy to make a couple of comments on that. One of the things that we identified soon after taking office was the fact that in our view things under the Charlie Parker regime have been over-centralised to the detriment of specialised treatment within health. Bearing in mind that health is a third of our local budget and a third of our local employees, we felt that it was important to give health more autonomy. The 4 areas that we identified where we wanted to have somebody specifically in charge was H.R. (human resources), I.T. (information technology), procurement and finance. In relation to H.R., we have now got our own specific H.R. director, and that gives us a lot more focus on managing all staff matters, staff conduct. That is going to put a lot more focus. That has only

been the case since October. But I think great strides have been made, and that has been done in conjunction with the head of H.R. in the States generally with their approval. We are keeping those 2 people very much in contact with each other while we try and put real focus on H.R. and conduct issues within health. It is an important part of what we are doing.

Deputy L.M.C. Doublet:
That is helpful, thank you.

The Minister for Health and Social Services:
That does help to drive culture change. I would also mention that this subject has been raised with the advisory board and they are keeping a close eye on that as well.

Deputy L.M.C. Doublet:
Okay, thank you. So the H.R. professional that you mentioned is now embedded within your department. Could you commit to having a discussion with them and potentially the senior consultants around the cultural issues that have been raised in this report to see what initiatives could be put in place?

The Minister for Health and Social Services:
We do have regular meetings anyway and cultural matters do, and we can make sure that they are ultra-focused, but there is a great deal of focus on culture change. I am not telling any tales out of school here, there have been bullying issues and so on, and all of that stuff I think is reducing and there is a particular focus on it. You only get culture change by putting the right apparatus in place and having the right disciplines at the top table, and that is what we are trying to achieve.

Deputy L.M.C. Doublet:
So could you commit to reporting back to the panel on the discussions that you have had with your H.R. team around the specific issues in here?

The Minister for Health and Social Services:
Happy to have a separate session on H.R. if you want. We can bring the H.R. director along, that would be fine.

Deputy L.M.C. Doublet:
Thank you. We look forward to hearing back about that.

Deputy P.M. Bailhache:

I think we have covered a bit of this ground already, but the words that we use are important and personally I am not comfortable with the use of the word “misogyny”, contempt for women. I would like to think that that is pretty rare in the Health Department. But what is concerning from the report is the impression that women are sometimes treated differently because they are women. I would like to know, perhaps from the Assistant Minister, whether she thinks that there is any prevalence of that kind of attitude in the department?

Assistant Minister for Health and Social Services:
I think if there is we would not tolerate it. This report is now slightly out of date, I think, and we have now a new chief officer in our Health Department and we have the new H.R. Department director, and I think these issues are very important. We think everybody, whoever they are, should be treated absolutely equally, and they should have kind and compassionate safe care.

Deputy L.M.C. Doublet:
How would you tackle it, Assistant Minister, if you found that was happening?

Assistant Minister for Health and Social Services:
I am sure that they would be reported to the chief executive.

Deputy L.M.C. Doublet:
Is there anything explicit that encourages reporting of this kind of treatment?

Assistant Minister for Health and Social Services:
I think we now have a speak-up guardian, and I think generally all the staff know that they are not allowed to accept any behaviour that is not appropriate.

Deputy L.M.C. Doublet:
Would you also seek to investigate whether that is something that is encouraged, the reporting of the specific behaviours identified in this report, and get back to us?

Assistant Minister for Health and Social Services:
It is, definitely.

Deputy L.M.C. Doublet:
It is? Okay, thank you.

The Minister for Health and Social Services:

I would also say that anybody listening, and I am not trying to get more emails than I get, but if there is any doubt from anybody, and they are scared to report this to anybody in the system, there are meetings with Assistant Ministers and email addresses. Lots and lots of people find them already. But if you get an instance of the sort that you are describing, and people cannot get the responses that they think they should be getting, they can always write to us, and we will ensure that that gets right through the system.

[12:30]

That is a personal guarantee for people. They can email us. A lot of them do, and we are getting a very, very good response, generally through the medical director or the I.T. Department, depending on which area we need to look at. But things are dealt with pretty sharpish.

Assistant Minister for Health and Social Services:
Can I also say that we have the Patient Advisory Liaison Service, which any patient is able to talk to? We do not want anyone to feel they are dismissed either because that is not good.

Deputy L.M.C. Doublet:
We did meet with them yesterday, so thank you for arranging that.

The Minister for Health and Social Services:
I am happy for people to go there first rather than come straight to us, if that is possible. There is a process. There is a system and it works pretty well.

Deputy J. Renouf:
Can I ask in terms of this report? We have been talking about specific things with it, is there going to be a departmental response to the report, a strategic response addressing the issues raised in it?

Assistant Minister for Health and Social Services:
So the Women's Health Political Oversight Group met yesterday and we came up with a plan but we just ... because it was yesterday afternoon I am very sorry we have not got it all written up yet. But a lot of the issues regarding women's health are not to do with the health service. They are to do with other things, wider things like financial security and housing, your life-work balance. There are lots of things we can do, but we want to work with Public Health. Do you want me to go through what we want to do?

The Minister for Health and Social Services:

If Ruth could actually articulate that, because Ruth's doing fully on the job.

Deputy L.M.C. Doublet:

If you can keep it concise.

Director of Health Policy:

The Women's Health Political Advisory Group met yesterday. They have identified 5 priority areas of action that they would like to address with regard to some of the key findings in this report. In a short period of time, we will be able to provide more detail around that. But also really importantly, as Andy says, what this report is doing is it is talking about women's health and well-being in the round. Many of the factors that affect women's health and well-being are not within the jurisdiction of the Minister for Health and Social Services. They are about stress, life-work balance. Some of the answers and solutions to those are about things like childcare, not just about the cost of childcare, but about wraparound care. They are about housing. They are about how women are enabled and supported to manage the particular burden that is common with those. The Minister for Health and Social Services, as I am sure you are aware, has made a commitment, which he has spoken about on a number of occasions, to actually set up and lead a Ministerial group looking at the determinants of health in the round. That will include women's health. This report and the findings of it will be fundamental to the work of that group. There is a 2-pronged approach to it.

Deputy J. Renouf:

But will there be a formal written account summarising how this is going to be responded to, including those overarching joined-up government pieces of work that will result presumably?

Assistant Minister for Health and Social Services:

Yes, we are. I mean, we want women on this Island to thrive, and we are all here to do the same thing; all of us. We will be writing to say what our actions will be as a result. We are very grateful for all the women who took the time to answer the survey because it has given us actual evidence now on which we can base. We produced the action plan in October and we will be going forward again with more of what we can do.

Deputy J. Renouf:

The final question on this from me is you mentioned in December 2024 that there would be a statement of intent that would be published as a result of this. Is that something that is wrapped up in what you have already talked about or is that something separate, and if so when is that going to ...

Assistant Minister for Health and Social Services:

It is the same thing.

Deputy J. Renouf:
It is the same thing, okay.

Deputy L.K.F. Stephenson:
How are you going to ensure buy-in? I appreciate you have a number of Ministers on the Women's Political Oversight Group already but how are you going to ensure that Government-wide buy-in from the Chief Minister, from all of the Council of Ministers? Are you going to take it to Council of Ministers as an item?

The Minister for Health and Social Services:
We are setting up a group with all of the concerned Ministers. But, as I say, I think health and service issues account for 20 per cent of women's and mental health, so we are going to look at all the other Ministers who are responsible for all the other areas and we will be starting to work together collectively to try and address all these problems as a concerted piece of work. I think unless we do that, unless we integrate those processes where one can look at ...

Deputy L.K.F. Stephenson:
But before, appreciating that that is going to take some time to come together as well, will the women's health response be going to Council of Ministers at the moment immediately?

Assistant Minister for Health and Social Services:
We only met yesterday afternoon, so we have not done it overnight, I am afraid. But we will work at pace as quickly as we can.

The Minister for Health and Social Services:
What is most important is that it goes to the executive leadership team and to everybody that is involved in looking at stuff so that we can get on and do the work.

Deputy L.K.F. Stephenson:
But appreciating that there are executive leadership teams in your department but there are across government who all need to work together on this.

The Minister for Health and Social Services:
That is why we are setting up a cross-Ministerial group to ensure we meet with all the relevant parties to make sure we join the dots.

Deputy L.K.F. Stephenson:

Yes, but that is a general health one of which you have said women's health will be a part of it. What I am trying to say is, women's health at this moment in time, how are you going to make sure you get that buy-in from everybody now in the immediate response to it as well?

The Minister for Health and Social Services:

To be honest, I think we have got buy-in already. This is a continuation. This is work in progress. This is not new to the Council of Ministers. They are fully aware of this, the women's health group, which is our Assistant Minister working on women's health. We have discussions with other Ministers all the time. As I say, it is work in progress. It is not something new. The next round of work that comes in, we have constructed the system and put it into practice.

Assistant Minister for Health and Social Services:

I commit to carrying on working with all of the team.

Deputy L.M.C. Doublet:

And the statement of intent will go to the Council of Ministers, will it?

Assistant Minister for Health and Social Services:

Yes.

Deputy L.M.C. Doublet:

Okay, thank you.

Deputy P.M. Bailhache:

I think it must be fairly obvious but I was going to ask who within Government, who within the department, is going to carry the specific responsibility for ensuring that these recommendations are looked at and seen through, and that presumably will be Assistant Minister Howell?

Deputy L.M.C. Doublet:

So I think we have touched a bit on this in terms of your statement of intent and the areas ... I am not sure if you actually outlined the 5 areas that you were going to cover in that. Could you just clarify what the 5 areas are and are they the 5 areas taken from the report?

Assistant Minister for Health and Social Services:

The first we are going to help with work and healthier lifestyle and for ageing well. We have targeted joined-up evidence-based programmes. We are hoping to improve work-life balance through increasing the childcare offering, but that will be dependent on working with the Minister for

Education and Lifelong Learning. We are going to improve screening uptake. We are going to have opt-out screening for breast cancer, opt-out screening for cervical cancer, and we would wish that the H.P.V. (human papillomavirus) vaccine updated data. Then we are looking at how we can improve gynaecological, how we can get rid of the stigma attached to menopause, get people talking about women's issues so they are not a taboo subject anymore. I think we have lots of work to do on that and we are going to then also look at how the contraception services are working.

Deputy L.M.C. Doublet:

Okay, thank you. So in this report some of the determinants of health that were mentioned around gender-based violence and safety concerns, how will you work with other Ministers to ensure that this is tackled?

Assistant Minister for Health and Social Services:

We have also committed to implementing the health recommendations made by the Violence Against Women and Girls Taskforce. So every G.P. (general practitioner) now undergoes something called I.R.I.S. (Identification and Referral to Improve Safety) training so they are aware of what to look for, what questions to ask.

Deputy L.M.C. Doublet:

Thank you. Could you update us as to the timings of those recommendations, when are they due to be completed from the V.A.W.G. (Violence Against Women and Girls) report?

Assistant Minister for Health and Social Services:

I think the I.R.I.S. training is already underway.

Deputy L.M.C. Doublet:

Do any of the officers have information about the timings of those recommendations?

Director of Health Policy:

I do not have the information off the top of my head but I can certainly provide it.

Deputy L.M.C. Doublet:

Yes, please do provide that to the panel after the hearing, thank you. I would also like to ask about another area that was identified in this report; economic inequality and financial stress, particularly on single parents. There is a notable gender pay gap in Jersey which can also have an impact on women's health. What is Government doing to tackle this?

Assistant Minister for Health and Social Services:

I think Government have identified that this is a problem, and I think for single mums ... often it is mums who are left looking after children, and I think it is really hard for some of them because they have to juggle 2 or 3 jobs sometimes and childcare to make ends meet, and then they do not have any ... what every woman needs to have is 5 minutes for themselves every day. But I know that is really hard. But that is what we should ... so we are hopefully working with the Minister for Children and Families, and he is starting a pilot for childcare for 2 to 3 year-olds, I believe.

Deputy L.M.C. Doublet:

It is great that you are aware of the difficulties that single parents face. What specific policy interventions are you planning to tackle those issues for single parents?

The Minister for Health and Social Services:

I think these are early days. We have not even had our inaugural meeting yet, so we are putting this group of people together and that is ongoing. Yes, there is not a roll-out ready to go. That is work in progress.

Assistant Minister for Health and Social Services:

But we have started free school meals for every child who needs them in, I think, all the schools; I stand corrected.

The Minister for Health and Social Services:

There is work going on in each department but it is not as well threaded together as it could be and as we intend to make it by virtue of initiating this group.

Deputy L.M.C. Doublet:

So are free school meals currently available to every single parent family?

The Minister for Health and Social Services:

To anybody, I think, in primary schools, is it not?

Deputy L.M.C. Doublet:

Could you check on that and report back to us please? If they are not currently available is that something that you would support?

Assistant Minister for Health and Social Services:

It is my understanding that they are available.

Deputy L.M.C. Doublet:

To single parent families?

Assistant Minister for Health and Social Services:
Every child.

The Minister for Health and Social Services:
Every child, I think.

Deputy L.M.C. Doublet:
It is not free for every child.

Assistant Minister for Health and Social Services:
It is not free for every child, but if your circumstances are such that you require it, then it is free.

Deputy L.M.C. Doublet:
So is part of that criteria, are single parent families able to access the free school meals?

The Minister for Health and Social Services:
I think it is a matter for the Minister for Education and Lifelong Learning. We cannot (inaudible).

Deputy L.M.C. Doublet:
Would you support that if it came to the Council of Ministers?

The Minister for Health and Social Services:
We would have to look at the detail.

Deputy L.M.C. Doublet:
Another group that face more barriers than some are women with disabilities. What specific policy interventions do you have to address this?

The Minister for Health and Social Services:
It is not something I am familiar with in terms of specific.

Assistant Minister for Health and Social Services:
I think everyone with a disability is treated equally and their disability taken into consideration.

Director of Health Policy:

You may well be aware of the work that is being done by the Minister for Social Security and through her team, which is around providing more support to people who have disabilities, whether they be men or women who have disabilities, particularly through the work around social prescribing and about creating social connections, because one of the things that we know about people with disability, and this applies to both women and men, is that not only do you have the challenges associated with your disabilities, but those often lead to a great deal of social isolation, which compounds mental health, which compounds loneliness, which creates the vicious circle. This is something that the Minister for Social Security, with her team, are directly tackling at the moment through their social prescribing initiatives.

Deputy L.M.C. Doublet:
There is evidence that shows that women are disproportionately affected by disabilities and also by long-term chronic health conditions such as auto-immune conditions. Is this something from a policy point of view, Minister, that you are aware of?

The Minister for Health and Social Services:
Not specifically, to be perfectly honest with you.

Deputy L.M.C. Doublet:
Now that it has been brought to your attention, would you commit to reflecting on that and examining what policy interventions you could make to address this?

The Minister for Health and Social Services:
I am surprised that the professionals that work in those areas are not aware of them and have not dealt with them already, but I am certainly happy to take that discussion to see the extent to which there is a problem.

Deputy L.M.C. Doublet:
Thank you, and if you could report back to us, we would appreciate that.

Deputy L.K.F. Stephenson:
The report also highlights gaps in gynaecological and reproductive care. What actions are being taken to address some of those gaps? For example, delays in diagnosis for conditions like endometriosis or polycystic ovary syndrome - I think we touched on that before - and address the lack of specialist support for these conditions. You will correct me if I am wrong, I am sure, Professor, that ... am I correct in thinking there is no ... for example, there is not somebody who specialises in endometriosis as a go-to individual? But who leads the service, is what I am trying to say. I think you have a lot on your plate, as it is, already.

[12:45]

Consultant Gynaecologist:
So endometriosis, approximately 25 per cent of women will have endometriosis, to some degree. If you look really hard for it, you can find it probably in over 50 per cent. Endometriosis is a very specific condition in that the amount of disease you have does not always correlate with the symptoms that you experience. You can see a woman with quite severe endometriosis with no symptoms, whereas women might have a few spots of endometriosis and have a lot of symptoms. So you have got to work through that pathway. The average age delay in diagnosis in women over the age of 21 is 5 years. This is in the U.K. basis. The average delay in diagnosis for women under 21 is 7 years, because the only way that you can diagnose it is through a laparoscopy. Everything else is subjective. The only objective way is through surgery, so you have to, at a secondary and tertiary level, make a decision between a risk-benefit analysis, how am I going to cause risk to this patient by doing surgery versus how likely am I to change the outcome. So if the woman comes with pelvic pain or menstrual pain then that is very well-managed in primary care with a presumptive diagnosis of endometriosis and using the oral contraceptive pill, as many of my primary care colleagues do. It is only when it comes to a reproductive failure or to persistent failure in the primary care, then that would come to my desk. Generally gynaecologists can look after it, but if it gets more difficult and there is what is called stage 4 endometriosis, then I would see it and my colleagues in the hospital would refer to me. Then I have the network to tie into.

Deputy L.K.F. Stephenson:
So to summarise, there is not, in the case of endometriosis, an endometriosis clinic as such. It is dealt with at primary care, but if it gets to affecting reproductive health it would come to you ...

Consultant Gynaecologist:
Or significant bowel or bladder involvement, then I will get involved as well at that stage. But this is similar to any D.G.H. (district general hospital) in the U.K. There are no specific endometriosis clinics. There are about 20 specific endometriosis centres set up in the U.K. and those are usually at tertiary levels. In general, my colleagues in the U.K. will manage this at a secondary level with many other conditions that are gynaecological but only if the diagnosis is stage 3 or 4, where it is involved in other organs, then is it referred on. It is quite similar for polycystic ovaries. Again one in 3 women have polycystic ovaries, one in 20 have polycystic ovarian syndrome. It is very well-managed in primary care through appropriate pathways and then referral on when there is treatment failure.

Deputy L.K.F. Stephenson:

The report highlights that there are gaps in those areas; do you accept that? Do you agree that there are some gaps there that could be filled or do you think it is all working in the best interest of the patient?

Consultant Gynaecologist:

I think that one of the joys of coming to Jersey 4 years ago is that this is a small community and it is a small medical community. I know that most of my gynaecological colleagues know what my expertise has been and hopefully a lot of the primary care team, and that is direct access. So if there is failure to access that service then there may be other perverse incentives or otherwise that are involved in that process.

Deputy L.K.F. Stephenson:

The relationship with G.P.s, primary care, do you think that is as good as it can be to allow those pathways to flow through to you?

Consultant Gynaecologist:

Yes, this is always ... you never achieve your goal and that is across health in general. If you think you have achieved it, then you are misinformed. You are always striving. There can be better information, there can be better relationships. We have more evidence coming out all the time on different disease conditions so you need to constantly update that and keep that information flow and those relationships alive. As new practitioners come on board who start working in practices need to understand, so frequent regular meetings with them. Having the Primary Care Board where we can disseminate information down is the ... but that is all we can do is disseminate the information.

Deputy L.M.C. Doublet:

In terms of information, one of the recommendations in the Public Health report was improving health literacy and education around gynaecological health. Is this something that will be carried out?

The Minister for Health and Social Services:

Yes, it will.

Deputy L.M.C. Doublet:

Is it underway already or could you advise the timescale?

Assistant Minister for Health and Social Services:

It is something that we are mindful that we need to make sure that every woman is aware of the various ... like I think in N.H.S. (National Health Service) Scotland, they have N.H.S. inform. I think we ... I am aware that it is a gap.

Deputy J. Renouf:
Just a question on Rayner Ward, can you provide an update on the refurbishment plans for Rayner Ward?

Assistant Minister for Health and Social Services:
So, we went for a visit last week and it is underway. It is closed at the moment, but they are refurbishing it.

Deputy J. Renouf:
When would it be planned to be brought on-stream?

Assistant Minister for Health and Social Services:
I think, hopefully, October.

Deputy L.M.C. Doublet:
Can I just clarify? So, Rayner Ward is the ward where the gynaecological services are delivered, is that correct?

The Minister for Health and Social Services:
Yes.

Deputy J. Renouf:
Can you provide any information on the status or content of the planned gynaecological improvement plan being developed?

Consultant Anaesthetist:
Yes, so the original plan was to incorporate a minor ops theatre in that area, but it is a very, very old part of the hospital, so we could not get the ventilation for that. We are redoing the outpatients area. The minor op suite will remain where it is, and the Rayner end of what is the surgical floor side ...

Deputy L.M.C. Doublet:
Sorry, would you mind speaking up a little bit? I have just had some indications that ...

Consultant Anaesthetist:

I have never been told I am too quiet. Basically we have 3 areas which we would call Rayner Ward. We have a minor op suite where we do colposcopies, outpatient hysteroscopies. We were planning on putting a minor op suite into the end of Rayner so that we could have one whole area, but we cannot do that because of the age of the building. It is in the old granite block, and we cannot get the ventilation that we need when we are dealing with colposcopy patients. That suite will remain where it is, which is in the Day Surgery Unit. Then the outpatient area is being totally refurbished. We will have 4 clinic rooms available for general outpatients, gynae outpatients, our early pregnancy assessment unit, our gynae oncology, all of our clinics will happen there. Then what used to be Rayner Ward, which is the far end of the surgical floor, will become a women's area. It will not just be gynaecology, it is going to be breast surgery, but that will be a women's ... basically a women's ward.

Deputy J. Renouf:

Moving on to questions of pain management. There have been persistent reports that women's pain is treated differently to men, assessed at a different level, given a different scoring and so on. Is this a problem in Jersey and what are you doing to tackle it?

Consultant Gynaecologist:

So pelvic pain, if it is pelvic pain, as opposed to any other type of pain?

Deputy L.M.C. Doublet:

General pain. So just to clarify, we are referring to a study that was led by King's College, so it is not necessarily Jersey data, but found that there was consistent differences in how male and female patients were treated for pain. Their pain scores were less likely to be acknowledged, less likely to be noted down, and they were less likely to be prescribed effective pain medication. What we would like to understand is that is the kind of national context, what is the situation in Jersey?

Consultant Anaesthetist:

I am an anaesthetist, but I am not a chronic pain specialist. But we have good access to the pain clinic; that is for chronic pain. We have 2 consultants and an associate specialist, all who commonly see women and men with chronic pain issues. I would be very interested to see Jersey data on that because I really do not believe there is a discrepancy.

Deputy L.M.C. Doublet:

We do have some Jersey information, it was highlighted as a concern in the report. What is your response to that, Minister?

The Minister for Health and Social Services:

My response to that is that we carry on this dialogue with the pain specialists. As I say, we are going deep into a particular specialist area that I am not able to answer those questions. I am very happy to have that discussion with the head of pain management.

Consultant Anaesthetist:

I think the pain ... I mean, you are talking about pain. There are so many different areas. If we are talking about chronic pelvic pain, which is a lot of the patients that we will see in the gynaecology clinic, that is one area. But chronic pain that is seen up at the pain specialist is different. It is such a huge ... it is 50 per cent of our population will have those sort of issues.

Deputy J. Renouf:

I wonder if you can clarify the criteria used to determine when pain relief, for example local anaesthesia and so on, is offered to patients during procedures and ensure that there is consistency so that men and women are treated equally in those situations.

Consultant Anaesthetist:

I know what pain relief we use for women who are having gynaecological procedures. I am an anaesthetist so I spend a lot of time anaesthetising patients, both men and women. We give women a patient leaflet prior to them having an awake procedure that recommends that they take analgesics prior to coming in, simple analgesics before and after. We use local anaesthetic block techniques when they are having hysteroscopies, and they can also use Entonox, like gas and air, for the procedures. We have that available. Very few people take that up, but some patients do. If they require ... we have a much higher number of patients who have a general anaesthetic for more simple procedures, such as Mirena device insertion, than we would have in the U.K. But I do not know about the differences between men and women other than I treat all my patients under anaesthetic in the same way.

Deputy J. Renouf:

The Government of Jersey website, in terms of contraceptive implants, coils, and so on, lists paracetamol and ibuprofen as the pain management but the private sector offers local anaesthetic or gas and air.

Consultant Anaesthetist:

That is the same in the hospital. Exactly the same in the hospital. I do not know about Le Bas Centre I am afraid, as to whether they do or not. But definitely we offer local anaesthetic. We do local anaesthetic if patients require it. A lot of patients do not. Simple analgesics is enough. But those, if they particularly have not had a baby before, will struggle with pain. As I said, that is why

often patients prefer to have a general anaesthetic or some sedation, but that has to be within the hospital.

Deputy L.M.C. Doublet:
How do women know that that is an option to have that effective pain relief if it is not visible on the website?

Consultant Anaesthetist:
So every patient is given a leaflet when they go to outpatients.

Deputy L.M.C. Doublet:
Okay, thank you. Minister, could you undertake to update the website so that the full range of pain relief options is made clear to women on the website? Thank you.

Deputy L.K.F. Stephenson:
Just a couple of questions about the breast screening service, and I noted you said earlier about moving to an opt-out system as well. I wonder if I could start by asking, the panel has been made aware that there is a limited number of mammogram appointments available at the hospital and that women are being signposted to the Enid Quenault, which we have heard anecdotally may be putting some people off, for example, if they cannot get there as easily in a working day. Is that something you are aware of?

Assistant Minister for Health and Social Services:
Can I pass you over to Sarah?

Deputy L.M.C. Doublet:
Can I just make a note about timings? We are already very behind on the timings, so we will need to speed up a bit to get through the questions, but please go ahead.

General Manager, Medicine:
So Enid Quenault has got a new purpose-built breast screening unit there and the idea of that is that it enhances the patient's journey. If you go for breast-screening mammography at the General Hospital, the patient journey is not very nice. The area where it is is not the best. It is next to oncology and that leads to not a great patient experience for a lot of people. The new breast screening service at Enid Quenault has been purpose-built and we have recently done a patient feedback survey, which we do to audit all our new services, and of that 89 per cent of people said it was very good and the other 11 per cent said it was good. But one of the really interesting parts that we found is people are perceiving that they are having less pain when they are having a

mammogram. So a mammogram is not painful but it is not comfortable to have, and we think that is because the environment is nicer for them because there is absolutely no change in the tests that they are being offered. If people cannot get to Enid Quenault then we can see them at the General Hospital but because of the environment we would prefer to see them up at Enid Quenault. That also then allows more time for our patients who are symptomatic to be seen at the General Hospital and frees up more slots for the cancer patient pathway.

Deputy L.K.F. Stephenson:
Great, and that is really positive to hear some good feedback as well, particularly around pain; very fitting given the last questions. Could I just ask, before we do move on, about the move to the opt-out system? Has that been coming already, is that in place, when is that going to happen, please?

General Manager, Medicine:
So that will happen this year, and that has been made possible due to the new site at Enid Quenault. Before that we only had one mammography machine so we physically did not have enough clinical space or time to see everybody. But we knew that we were missing some women. We had done an audit, and we knew that people were not registering, as they should do. That was one of our targets last year with the women's health and with the cancer strategy to make it opt-out. Now the new site has been operational since November, we are working to make it opt-out, and it will be fully opt-out by the end of this year.

[13:00]

Deputy L.M.C. Doublet:
In your answer there, you managed to cover pretty much all of the questions we had planned, so thank you very much. We are going to move on now to contraception, and, Minister, in a previous quarterly hearing we discussed how young people are facing some challenges with accessing information around different contraception options available. Has that evolved since the quarterly hearing in autumn of last year? Has the support there improved at all?

Assistant Minister for Health and Social Services:
That is something that we discussed yesterday afternoon at our meeting, and it is something that we will be working on, but it is quite complicated because we need to work with the clinicians and the policy, everybody; it is a joined-up piece of work.

The Minister for Health and Social Services:
It is probably useful for Ruth to give you a very quick rundown.

Deputy L.M.C. Doublet:

I am noting the time. There has not been any movement yet, but it is part of your plans? Yes, thank you. So, we also discussed about the very high demand for access to free contraceptive medication from community pharmacies. I am going to read a quote from this report from somebody who filled out the survey: "The Government should set up a similar sexual health clinic that is free. Even having to pay for my contraception pill now feels unfair when men do not have to pay for this. There are free condoms available everywhere. Why is the price burden put on women?" Can you respond …

The Minister for Health and Social Services:

I am going to ask Ruth. Ruth knows chapter and verse on this.

Deputy L.M.C. Doublet:

We will go through with the second; could I just have your reaction to that quote, Minister? Or Assistant Minister. Whoever wants to respond to that.

Assistant Minister for Health and Social Services:

It is something that we addressed; we are in the process of addressing.

Deputy L.M.C. Doublet:

Okay, so it is part of your plans to make the contraceptive pill …

The Minister for Health and Social Services:

It is one of the 5 issues that we …

Assistant Minister for Health and Social Services:

It is one of the 5 things. We have to look very carefully. At the moment, contraception is free for everyone up until 23 …

The Minister for Health and Social Services:

If it is helpful, I think for Ruth …

Deputy L.M.C. Doublet:

No, it is okay, you can finish.

Assistant Minister for Health and Social Services:

At the Le Bas Centre up until 23. If you go to your G.P., the G.P. is now free up until 18 or up until 21, if you are a student. Then that is completely free. It is something we are working on.

Deputy L.M.C. Doublet:

Yes. The charge, I think, if you are having the 2 G.P. appointments per year with perhaps free prescriptions, it ends up being around £100 a year roughly, does it not?

Assistant Minister for Health and Social Services:

Yes.

Deputy L.M.C. Doublet:

So that is the cost, I think, that women are facing.

Assistant Minister for Health and Social Services:

Yes, and in fact I think … yes.

Deputy L.M.C. Doublet:

Sorry, let us just let …

Deputy L.K.F. Stephenson:

I was just going to say that previously this piece of work had been delayed, I think because of resource challenges. Can you just confirm you have got the resources to go ahead with it this time?

The Minister for Health and Social Services:

Same resources; it is moving up the priority list. As I say, we are very, very tight on resources. I am very, very keen for Ruth to explain how the situation has evolved and how confused it is at the moment.

Deputy L.K.F. Stephenson:

So it has moved back up the priority list, is the …

The Minister for Health and Social Services:

It was on the previous list of 3; it is now on the (inaudible).

Deputy L.K.F. Stephenson:

Thank you.

The Minister for Health and Social Services:

It would be helpful for everyone to understand how we carry out the process in this.

Deputy L.M.C. Doublet:

Can you do it in 30 seconds?

Director of Health Policy:

Certainly. The situation is a mess; we have no single coherent offering for women. We are acutely aware of that. Once we have got the Termination of Pregnancy Law work that we are currently doing done, we will turn our attention to how we develop a single, simple, coherent contraception offering for all Islanders. That does not necessarily mean that it will be free for all Islanders, but we will certainly focus on good access to affordable contraception for the majority of women.

Deputy L.M.C. Doublet:

Thank you. I think that was probably less than 30 seconds. In terms of access to medication, the panel has received submissions which raised concerns around the emergency hormonal contraception, which is called the morning-after pill, available to Islanders over the counter. We have heard that the statistically more effective option is considerably more expensive in Jersey than the alternative option, which is less effective, and that women are therefore choosing the less effective option, which may lead to terminations or unplanned pregnancies. Were you aware of this issue?

Assistant Minister for Health and Social Services:

No, but I did phone up 2 pharmacies this morning. One said that it was £25 and £35, and the other said it was around £20.

Deputy L.M.C. Doublet:

Okay. Now that this issue has been brought to our attention, Minister, would you commit to discussing with the Minister for Social Security how you might tackle that issue with the Health Insurance Fund?

The Minister for Health and Social Services:

I would be happy to.

Deputy L.M.C. Doublet:

Thank you.

Assistant Minister for Health and Social Services:

I think that if you had a free G.P. appointment, then it would be free up until the age of 21, if you are a student, or 18 if you are under 18. So at the moment, there are some categories who do receive it free.

Deputy L.M.C. Doublet:

Okay. Are you aware that this medication is going to be made free of charge in England later this year?

Assistant Minister for Health and Social Services:

Yes, I am aware. But unfortunately, we cannot promise everything to everybody; we are under constraints.

Deputy L.M.C. Doublet:

Thank you.

Deputy J. Renouf:

If we move on to I.V.F., we have heard in the past - or we know - that you have resisted broadening the criteria for I.V.F., and therefore there are some groups who are not able to access I.V.F. at the moment.

The Minister for Health and Social Services:

I do not think we have resisted anything at this stage. We are only in our fourth month of operation. I think what we are doing is we are monitoring how everything goes, and I think we are quite happy to revise the criteria going forward, but we need to analyse everything that is taking place and take a look at how to deal with it. There is no reluctance on our part to change criteria. As I was saying, there was an awful lot of work that went into this in a very short space of time and I think so far - I do not know what your thoughts are - that it is working, 16 weeks in, reasonably well. There have been some inequalities identified and we are happy to look at those and look to address whatever emerges from the situation. It is in its relative infancy, I think we all agree, so we are happy to keep an open mind on what we do.

Deputy J. Renouf:

Can you explain what that process is of review that you are doing, looking at that service? How responsive are you able to be?

Director of Health Policy:

So perhaps I … or did you want to take that one?

Consultant Gynaecologist:

I am very happy to. We collect in A.R.U. all of the data around the couples who are eligible and the couples who are not eligible and then go forward to self-funding. We then can analyse on what

criteria have they not been eligible. Then inside the funding bracket, every quarter we are referring back to the Ministry again with how much of the budget we spent and giving estimations: "If you were to relieve this, this would result in this amount more spent." So, that there is a process where you can move forward and you can have, hopefully, sustained funding as opposed to ending up with no budget at the end of 6 months.

Deputy J. Renouf:

Okay. Are you able to share any indications on what kind of messages you are able to convey about that?

Consultant Gynaecologist:

Yes, at the moment we are slightly under budget spend. The biggest criteria of where couples are not eligible is where there is already a biological child inside that couple; so, they have their own child. That accounts to about 60 per cent of the groups that are not eligible; so, there is already a biological child. The next group is where there is a biological child by one or other partner outside that relationship. The third one would be where the woman has got a higher B.M.I. (body mass index), smokes; so, other criteria that actually will affect the effectiveness of the treatment. We know if the B.M.I. goes over 30 it severely decreases the chance of I.V.F. working. If you smoke, it decreases. So quite rightly, there should be a B.M.I. indication, there should be a smoking indication.

Deputy J. Renouf:

You said part of that process is to advise the Minister on how you might go forward. What advice are you currently giving?

Consultant Gynaecologist:

Well, the advice is objective: "Here are the numbers we have treated; here are the groups that are not eligible; here is what it would cost if you make this group eligible; and here is your budget."

Deputy L.K.F. Stephenson:

Do you know how much it would cost to make the first 2 groups eligible? How much extra? So, when there is already a child inside the relationship or outside?

Consultant Gynaecologist:

Where there is already a child inside the relationship, there have been, for example, 6 couples who have self-funded since this has started. So that would then put an extra £20,000 on to your budget, which would make us overspend at the moment on our quarterly run rate.

Deputy L.K.F. Stephenson:
And that is in 4 months?

Consultant Gynaecologist:
Three or 4 months. If you extrapolate out, your budget is gone by the end of the summer. That may be something that you want to do; like Scotland, for example. Scotland have a fixed budget, and they say: "That is the budget for fertility services. Once that budget is spent, there are no more fertility services that year, and it goes on to the next year." But then it is transparent and open and everybody can have it, but then you create a waiting list. So the waiting list for I.V.F. in Scotland is up to 2 years in the N.H.S.

Deputy L.K.F. Stephenson:
Just on the third category, I think you talked about B.M.I. Where patients are not eligible for B.M.I., how are they dealt with? Are they signposted elsewhere to help address that for them? Because it can be quite difficult to just be turned away.

Consultant Gynaecologist:
Of course. The first part is education, saying why is there ... either on a state-funded or from a success rate, why does it affect it, why is there excess hormones produced in the fat tissue that will suppress the response? So, educating and then reviewing and reinforcing that message is very important. Then for anybody who is between the B.M.I. of 30 or 35, if they want to self-fund, the I.V.F. units will usually accept them. But over 35, a lot of centres will not accept them, because then you are into an anaesthetic risk at the time of egg collection, and it creates a risk-benefit analysis over the whole thing. We certainly do not discharge people because of their weight. I will very quickly review them, see them again, reinforce. We need to see people working towards it. But you have got 4,500 Type 2 diabetics in Jersey, around weight. If you give them all G.L.P.-1 (glucagon-like peptide-1) antagonists, you would save significant money going forward, but that will cost you about £7 million, I think it is, on the current cost.

Deputy L.K.F. Stephenson:
For the laymen around the table …

Consultant Gynaecologist:
Tirzepatide(?), , sorry.

Deputy L.K.F. Stephenson:
For the non-medical people in the room, that is medication to help them lose weight? That is weight loss jabs, for example.

Consultant Gynaecologist:
It is suppression of appetite, yes.

Deputy L.K.F. Stephenson:
Yes, fine. Okay. Thank you.

Deputy L.M.C. Doublet:
Still on the topic of assisted fertility, we have also found on the panel that parts of the L.G.B.T.Q.+ (lesbian, gay, bisexual, transgender and queer) community face inequitable access to funded I.V.F. I know it is something you are aware of. I think it is around 6 rounds of I.U.I. (intrauterine insemination) are required before they can access the I.V.F. - for a same-sex female couple - and this can cost, I think, around £4,000. This has been dubbed a "gay tax" and concerns that it is biassed. What comments do you have on that?

Assistant Minister for Health and Social Services:
Yes, so I do accept your comments and it would be something that we would look at, but we have to be … you know, there are men who would like a surrogate baby and they do not get any help. I wish we had an infinite amount of money for that, that we could do everything, but I am aware that there is not.

Deputy L.M.C. Doublet:
For same-sex female couples, obviously it is different processes; is this something that you could commit to reflecting on and get back to the panel?

Assistant Minister for Health and Social Services:
Yes, it is something we have to …

Consultant Gynaecologist:
I think it goes down to, again, your definition. An infertile couple is a couple who cannot get pregnant; by definition, same-sex couples are not infertile. It is the same as onco-preservation; if you have a woman or a man who has gone through cancer treatment and they have preserved their gametes before chemotherapy, in the U.K. that is a separate budget from your fertility budget. So, you need to look at a different budget, per se, because the W.H.O. (World Health Organisation) definition of infertility and eligibility for I.V.F. is very clear. That group, until they have gone through those 6 cycles of donor insemination, do not meet it … which, I agree, because it is an easy win because they get pregnant usually very quickly.

Deputy L.M.C. Doublet:

Yes, and given the fact that our same-sex parental rights legislation requires families to use assisted reproduction to access parental rights where it is a same-sex couple … do you agree that this cost should be looked at?

The Minister for Health and Social Services:

All of it is under review, the whole process.

Deputy L.M.C. Doublet:

Thank you.

Deputy L.K.F. Stephenson:

Given the last comment there, that actually they often get pregnant quite easily, to put that in the context of the declining birth rate that the Island has, and taking it back to a wider Government conversation …

The Minister for Health and Social Services:

I think we need more than I.V.F. to solve that one.

Deputy L.K.F. Stephenson:

But I.V.F. births sit around the 5 per cent mark in our Island; it is part of the story to commit to taking that into account.

The Minister for Health and Social Services:

We are conscious, actually, of everyone's remarks and we are looking at all of it. We just need a little bit more time.

Deputy L.M.C. Doublet:

Okay, thank you. We are going to move on to miscarriage support. What immediate and long-term support services are available to women in Jersey who experience a miscarriage?

Assistant Minister for Health and Social Services:

Is it all right if we ask Ros Bullen-Bell, who is in charge of …

Deputy L.M.C. Doublet:

Yes, please do.

[13:15]

Consultant Anaesthetist:
Actually, I can answer this. We have recently got a new substantive consultant who is now going to be the clinical lead for the Early Pregnancy Assessment Unit. We have done a large piece of training on early pregnancy, on scanning. We now have a scan machine down in E.D. (Emergency Department) so we can have early access to scans if needed in the Emergency Department. But we now run a daily Early Pregnancy Assessment Unit clinic. We have an amazing counsellor who will see women after their loss, who is based up at Enid Quenault. We are doing a big strategy on the Think Ectopic as well, which has come from the U.K., but we are doing a lot of training related to that.

Deputy L.M.C. Doublet:
Thank you. Can I pick up on the counselling that you mentioned; is that offered routinely or automatically?

Consultant Anaesthetist:
It is offered automatically.

Deputy L.M.C. Doublet:
Okay, and how many women take up that offer?

Consultant Anaesthetist:
Ros would know that.

Director of Midwifery and Nursing for Women and Children:
Probably at least 50 per cent of them.

Deputy L.M.C. Doublet:
Okay, so around 50 per cent of women take up that offer. How is the effectiveness of that counselling measured?

Director of Midwifery and Nursing for Women and Children:
I would say that that is through audits, because some of them will require maybe one session and some will require more. So it is, again, exactly how many sessions they require within that time. We make sure that we review that regularly and it is always reviewed on a regular basis.

Deputy L.M.C. Doublet:
Okay, so it is reviewed on a regular basis?

Director of Midwifery and Nursing for Women and Children:
Yes.

Deputy L.M.C. Doublet:
Okay. I have been asked by officers to note about mics; if somebody from your team behind needs to answer a question, Minister, if they could swap in and out. Also, for us all to remember to speak into the microphone. Thank you, and welcome. Would you like to introduce yourself?

Director of Midwifery and Nursing for Women and Children:
I am Roslyn Bullen-Bell; I am the director of Midwifery and Nursing for Women and Children.

Deputy L.M.C. Doublet:
Go on. One more time.

Director of Midwifery and Nursing for Women and Children:
Do it again? Roslyn Bullen-Bell, director of Midwifery and Nursing for Women and Children.

Deputy L.K.F. Stephenson:
Thank you. Can I just pick up on the ectopic pregnancy … you talked about training and strategy. Has that been led by something happening locally? There were a few high-profile cases that ended up on social media, for example, over here. Is it as a result of concerns being raised, or is it just something that needed to be done following the U.K.'s lead?

Consultant Anaesthetist:
One of the things I have done, coming into my job, is focus on the governance around the Gynaecology Unit and obstetrics, but particularly gynaecology. We now have weekly risk meetings for gynaecology; we have a very transparent Datix system, which is when we report any incidents. We have had 2 serious incidents that related to ectopic pregnancies that have been fully investigated and the learning shared. Part of the thing is getting the learning shared, which has been really difficult, but now we have the weekly meetings where we share the learning. We are trying to make it a no-blame culture, so we are really trying to break down the barriers of learning. But yes, there have been 2 incidents that we have looked at.

Deputy L.K.F. Stephenson:
Thank you.

Deputy L.M.C. Doublet:

Okay, thank you. Are there any plans for reviewing the clinical pathways and also the information available for women undergoing pregnancy loss?

Consultant Gynaecologist:
I also lead on the recurrent miscarriage clinic. One in 3 pregnancies will miscarry; those are just the statistics nationally. Recurrent miscarriage used to be diagnosed as 3 or more miscarriages, at which stage that merited referral to a tertiary centre or secondary centre for investigation; and there are some - maybe 5 per cent of the times - you can find a reason for their current miscarriage. Having worked with the team in St. Mary's on this, that has now been brought down to 2 miscarriages. The clinic up at Enid Quenault, which we have, again, it is a direct referral; so either the midwife team or our colleagues down in the hospital can refer up and we will see them immediately. We will see women after 2 miscarriages. We will investigate them and, importantly, we will offer them with their next positive pregnancy test early ultrasound scanning, support, direct contact with the nursing team in A.R.U. to support them through that next pregnancy, which is very distressful for them and when they need that support. So, we have the primary care level where they have the first miscarriage, as Caroline has talked about, at the hospital. If they go to a second miscarriage or more, then they come up to our team at A.R.U. and we look after them there.

Deputy L.K.F. Stephenson:
Bearing in mind that sometimes those very early losses are happening at home for women and they are not even necessarily on the radar, even in primary care, can women self-refer?

Consultant Gynaecologist:
Definitely, yes.

Deputy L.K.F. Stephenson:
Do you think the message is out there enough so that women know that?

Consultant Gynaecologist:
We propagate that down through the Primary Care Board, and if there is any other way that we can put it forward - websites - we will do it. If you have had 2 confirmed miscarriages. So, not: “My period was a bit late.” We need to know that it was a confirmed. But even if it is not a confirmed, they still have a psychological need to have a conversation, so we are very happy to see them. We do not have any waiting time. We are quite efficient in the clinic, so we can see them inside 4 weeks.

Deputy L.K.F. Stephenson:

I wonder if that is something I could ask the Ministers if you could look to maybe do some communications around that? Because I do not think, personally, that is a message I have seen. The “2” number, I think it could be really helpful.

Assistant Minister for Health and Social Services:
Until very recently I was not aware of it either. Part of our plan is that we need to let people know what is available.

Deputy L.M.C. Doublet:
Okay. Thank you. We are going to move on to questions about the home birth service.

Deputy J. Renouf:
The home birth service was suspended and is currently suspended. This is a political question, I think, really. How does that decision align with the need to emphasise women's autonomy in reproductive health?

The Minister for Health and Social Services:
It was not a decision taken for personal reasons; it was a decision taken on professional advice. I would have to hand over to Ros to articulate what those reasons were.

Director of Midwifery and Nursing for Women and Children:
I think the decision was taken … obviously it was a proactive and precautionary measure because when I came into post I reviewed all of the services within the maternity improvement plan, and one of them was the home birth service. I became aware quite quickly that it is not about the experience of a midwife being able to be at a birth; it was more about coping with emergencies within the community setting, be that within a neonate or within the mum herself. That then led to me to think that I absolutely had to look at the training and the resilience of the staff and make sure that we have a model that absolutely is appropriate to provide adequate and safe service within our home birth. We then very much looked at the reasons for the home birth service. We have done a massive mapping exercise on that as well to pull out where we feel that we need to strengthen things, one of them being our guideline, our criteria. The training is the one aspect that we are sitting on at the moment, that we absolutely have to get done. That training is planned for 3rd July, which we are doing with our paramedics as well as our midwives.

Deputy J. Renouf:
I will come to the future in a moment, but what options and support are currently available for women who are planning or would like a home birth?

Director of Midwifery and Nursing for Women and Children:

At the moment we are unable to give them a home birth because we have not got the training and the support of it, but we have got a midwife-led unit. We have got 2 birthing rooms that are midwife-led. One of them has got a birthing pool within it. The other one is called the active birthing room, which has got birthing chairs, has got birthing cushions, has got cubes, et cetera; so it is a variety of things. Any woman who actually requests a home birth at the moment, I am actually meeting with the majority of them myself alongside their named midwife so we can talk that through with them and that they can understand the reasons behind the temporary suspension of the home birth service.

Deputy J. Renouf:

You say "temporary suspension"; what timetable or any kind of information can you give us about when home births might be available again?

Director of Midwifery and Nursing for Women and Children:

Once we have done the training, which is the beginning of July, then we will be going to our chief officer to give him all of the information to give him that assurance that I feel that we are ready to reinstate. Then it is for him to make that decision if he is happy on that date; so I cannot give you a timeline at the moment on that date, but I will be going to him in July with all of the information and giving him all the assurance of what we have done in that time.

Deputy J. Renouf:

Is there anything that would stop the home birth service for a more long-term reason? Could it be that you would recommend: "No, we are not going to do home births"?

Director of Midwifery and Nursing for Women and Children:

No, my intention is absolutely to recommend its reinstatement. I think the one thing that I need to tell Islanders is that we are on an Island, that we have to make sure that we are looking at our activity and our acuity and our staffing at any one given time. Our priority is to try and make sure that we have got a home birth service but we will never, ever be able to give it 100 per cent because if it was that we were busy within the unit, we have to look at our activity and acuity and staffing. My intention is to make sure that our staffing is utilised effectively and efficiently for every single woman that requires maternity care at any one given time, but we want to actually have it as a service that we are able to do. If it was that I was able to offer it 100 per cent, we would have to have significant investment in the number of midwives that we would have to have on our books at any given time. At the moment, we have got a set number for the number of births we do, but if we wanted us to provide a 24-hour service for that as well, we would have to increase the number of midwives that we had on the Island.

Deputy L.M.C. Doublet:

Understood. I just want to ask about the home birth service as a whole, because as I understand it, part of that home birth service was a community midwife would be able to visit a woman in her home rather than her having to go into a setting. That continuity of care, I think, was easier to achieve with a home birth pathway. Are you able to still offer some of those elements to women who feel that they need that?

Director of Midwifery and Nursing for Women and Children:

Now we have a hybrid model of our maternity units, in that we have some of our midwives work 50 per cent within the unit, 50 per cent within the community. Therefore, they are getting to meet a lot more midwives. There will be 2 named midwives for that one woman, so she will get to know that midwife as well. We are trying to do that continuity of care. As part of the work for the home birth service, we are also looking at the continuity of care and at team concepts, et cetera, as well so that we can strengthen that that continuity of the carer within that. That has given us that opportunity to be able to do that as well.

Deputy J. Renouf:

Minister, you have spoken in the past when you talked to us about the possibility of charging for the home birth service. Is that something that you still are taking forward?

The Minister for Health and Social Services:

No, that was in the context of if the population generally wanted a 100 per cent guaranteed, 24/7 service. As Ros has rightly pointed out, it would cost a significant amount of money. I am led to believe we have also got a bizarre solution for home births to … right amount of people (inaudible). There are other complications with it, but it would cost a lot of money. Given that we have not got anything spare in the budget, I have to be guided on best practice and safety. That is where I am. So, the service will come back when it is ready to come back on, and it will be the sort of service that we can afford within the financial budget that we have..

Deputy J. Renouf:

But can you clarify, is it still your intention to propose some charging mechanism for home births?

The Minister for Health and Social Services:

No, it was an immediate statement to … I am not sure what services will be available if somebody wants to pay (inaudible) to come in from other ... that was the point I was trying to make. If somebody wants that, it is a service from elsewhere that would have to be the way it is. I make it plain again,

and it has been made plain today, that the service can only be offered to the extent to which it can be affordable in the current financial budget.

Deputy J. Renouf:

Okay, so it will be free, but it may not be as extensive as …

The Minister for Health and Social Services:

As I understand it - correct me if I am wrong - we have never had the service that was guaranteed 24/7, 365 days a year.

Director of Midwifery and Nursing for Women and Children:

No, to have that you would have to have an awful lot more midwives. Within the number of births we have, we have got absolutely adequate midwives to be able to perform everything, but we never know within the maternity service what is going to go on at any given time. I need to make sure that every single woman is getting appropriate care, be that in the right setting. The first thing, sometimes you have to send 2 midwives out, might be that we are not able to give a home birth, but women will be aware of that. But we want to try and make sure that every midwife is trained so that we can give them the best opportunity to be able to have a home birth if that is their choice.

The Minister for Health and Social Services:

If the money was available, that would be great. But I think that virtually everything we have discussed today is give me more money, I think you would agree.

Deputy J. Renouf:

I think the issue that sometimes is made is that abortion, women have to pay for; home births, they may have to pay for - at least that was being discussed - contraception is paid for. There is a lot of women's issues which are lower down the list of priorities, it seems, in terms of payment.

The Minister for Health and Social Services:

I do not accept that, to be perfectly fair. As I say, we are constrained by the money that we have. If you can help in some ways - as politicians do - increase our budget, then that is fine by me.

Deputy J. Renouf:

But it is a £320 million budget and you have employed 190 extra people in the last year; so, money is available for some things.

The Minister for Health and Social Services:

I make this point again - I know we are short on time - but I was looking at the internet the other morning; the year I was born, I think the life expectancy was just over 71 years. It is now about 82, 83. People are living another 10, 12 years longer and medical science is every year coming up with more drugs, better operations and more financial requirements to keep people well for longer. We cannot square that circle. Our budget is rising exponentially and that is a reflection of all of the increased costs that we have to bear. We are in a no-win situation.

Deputy J. Renouf:

But do you accept the point that, from the outside at least, it looks like women's health issues always are the ones that go down to be paid for or be more difficult?

The Minister for Health and Social Services:

No, I do not think that is necessarily the case. As I say, if we can make changes, we will; but we are constrained. We face every day, the team faces very, very difficult decisions as to where they apportion the money.

Deputy L.M.C. Doublet:

What evidence do you have, Minister, that that is not the case?

The Minister for Health and Social Services:

Well, I would put it the other way round: where is your absolute evidence that it is?

[13:30]

Deputy L.M.C. Doublet:

One of the findings in the *Women's Health and Well-being Needs Assessment* was that women reported that cost is hindering their ability to maintain their health. How would you respond to that?

The Minister for Health and Social Services:

I would argue that we have not got a men's health group; we have not done any work on men's health or children's health and it may well be the same for them. I am not saying that there are not issues here; I have made that plain all the way through. If we could do better than we are doing, we would. But if you feel that money should be transferred from another area of health to women's health, that is fine, but we would have to go through that and we would have to justify whose operations you are going to stop, which cancer you might stop. These are very, very difficult decisions. I say, I get some very, very compelling emails in my inbox from people looking for more money to keep them alive, for example, and we have to go through a process for that too. So, it is not a game; nobody is anti-women here at all. These are just very, very difficult decisions.

Assistant Minister for Health and Social Services:
Can I just say that we have reduced G.P. costs for everyone during our term and we have also made period products free and there is no charge for termination of pregnancy if you are under 18, a student or if your pregnancy is a result of sexual assault.

Deputy L.K.F. Stephenson:
Minister, I think sometimes women, but maybe those around them as well, would just like to hear an acceptance of some of the evidence that is put forward from your own Government as well.

The Minister for Health and Social Services:
I am not refuting any of it.

Deputy L.K.F. Stephenson:
But just an acceptance and acknowledgement that yes, there are challenges and yes, there is data showing this. I appreciate we cannot solve everything and you certainly cannot solve everything yourself with a limited budget as well, but I think that is one of the things the panel would just like to hear is an acknowledgement of those challenges that do face women - because we are in a women's health hearing - rather than just a defensive attitude. I suppose that is what we are asking for on behalf of the public.

The Minister for Health and Social Services:
I will make it plain, okay. I accept everything that is there and I acknowledge it completely.

Deputy L.K.F. Stephenson:
Thank you.

The Minister for Health and Social Services:
I am very keen, as I said at the beginning of it, to resolve as much of it as I can, as quickly as I can. I take my role very seriously in terms of, as far as I am concerned, if I can politically help to improve the overall health service, as I say, when the time comes, it is all about (inaudible) and I can do a lot for women's health by concentrating on making a more efficient service. That is why we devised a partnership board, which I think is going to make things better. And as I have made plain on a number of occasions, I will be coming to the Assembly for a lot of money to improve preventative care - and women's health issues will come into that very clearly - and digital connectivity. We are talking of a sum probably in excess of £100 million over 5 years. I want that as additional money; I do not care where it comes from, if it come from the Strategic Reserve or whatever. If we make the health service more efficient and more effective, that gives us more money and therefore more

efficient and more resources to put to women's health. Very, very happy to do that. I have said all along, I have got no issue here at all; very keen to make it all better.

Deputy L.K.F. Stephenson:
Thank you. I appreciate the acknowledgment and I am sure others do as well.

Deputy L.M.C. Doublet:
Thank you. Do you want to follow up?

Deputy J. Renouf:
That was very interesting to hear you talk about the money there. Can you talk at all about how that process of getting the money, accessing Strategic Reserve and so on, is going?

The Minister for Health and Social Services:
I know I am being listened to and I do not want to create unnecessary headlines. I am using that as an …

Deputy J. Renouf:
Well, we do.

The Minister for Health and Social Services:
Fine. But I do not want to make unnecessary controversy. But as an Island, we have got reserves. We have got a Strategic Reserve. We have got problems in health. We have underinvested. We have failed to recognise the exponential rise in health costs. Health is being criticised horribly. When I first came to this, all the pressure was on health: "You are overspending. You are wasting money." Yes, there were elements of waste, but there are a lot of good people doing a lot of good work and they are confronting a huge amount of very complex problems. As I say, we take our role as being, in the round, trying to improve all of that.

Deputy L.M.C. Doublet:
What I wanted to ask, Minister, is do you acknowledge the findings from the report that there is a disproportionate need for healthcare from women as opposed to men - and therefore perhaps a greater need for investment - and will you prioritise accordingly?

The Minister for Health and Social Services:
I will acknowledge anything you … well within reason, anything you say. I cannot argue; I would not argue with anything that has been presented. As I say, there is a real commitment from everybody and some really good people working very hard to try and deliver that.

Deputy L.M.C. Doublet:

So we can expect to see the findings from this report reflected in your policymaking going forward?

The Minister for Health and Social Services:

To the greatest extent possible, yes.

Deputy L.M.C. Doublet:

Great, thank you.

The Minister for Health and Social Services:

Do you want to touch on capital and the bigger picture stuff?

Deputy J. Renouf:

Well, I was going to say "per capita" rather than "capital". Per capita, our health spending is roughly similar to the U.K.'s; do you feel that we need more than, say, what the U.K. is spending per capita?

The Minister for Health and Social Services:

If I am perfectly honest, it depends on whether we want a better health service or not. I would argue, and perhaps there are some professionals here that might bear me out, I think our health service is as good as anywhere in the U.K. I know there are points of excellence in the U.K. with specialist centres and so on, but I would say generally, I would be just as happy to be treated in Jersey as anywhere else and probably more so. I think we start from a pretty good base, but in an Island where we are trying to attract people to come and work and to live and to come on holiday and to invest money, we have got to do more to tick every box and make sure we are right. One of those things is a new hospital; that should be there in 4, 4½ years' time. It is our absolute intention to try and make sure we have got a first-class health service to put into a first-class hospital. I think it will take all of 4½ to 5 years to achieve that.

Deputy L.M.C. Doublet:

Thank you. We are going to move on now to the Termination of Pregnancy Law amendments, which I know you are working on, Minister. Can you briefly describe how this amendment will address any barriers to accessing these services, particularly related to stigma and reliance on G.P. referrals? Two things that were highlighted in this report.

Assistant Minister for Health and Social Services:

I think we are hoping with the new Termination of Pregnancy Law that women will be able to self-refer into the termination clinic.

Deputy L.M.C. Doublet:

Okay. In terms of stigma, how is your work tackling the stigma associated with access and terminations?

Assistant Minister for Health and Social Services:

If it comes about, you will only have to have the agreement of one doctor.

Deputy L.M.C. Doublet:

Okay, thank you. In terms of the cost of accessing a termination in Jersey, there is a significant difference in the fees for Jersey residents, £185, versus non-residents, £511. How will you ensure that cost is not a barrier to low-income or any vulnerable non-resident women such as migrant workers or carers, Assistant Minister?

Assistant Minister for Health and Social Services:

It is another difficult question.

The Minister for Health and Social Services:

Could ask Ruth, who has been working on the policy drafting, who can give you a fully comprehensive answer.

Deputy L.M.C. Doublet:

Can I just ask for the Assistant Minister's reaction to whether she feels those costs are appropriate?

Assistant Minister for Health and Social Services:

I have written a Ministerial Decision, so if you are under 18, if you are a student under 21, or if your termination is necessary as a result of sexual assault, there is no cost involved. But unfortunately, it is always a very hard call.

Deputy L.M.C. Doublet:

Why is the cost so much higher for non-residents, Minister?

Assistant Minister for Health and Social Services:

I think it is to do with paying into the social security.

Director of Health Policy:

The costs associated with termination of pregnancy are historic; I cannot start to work out or explain why they are what they are. What we are doing as part of the amended law is we are introducing

an order-making power, so the termination of pregnancy fees are developed by order, which therefore requires a degree of vigour. It also means that, in developing those fees, the Minister must accord with the Public Finances Manual and there cannot be any degree of overcharge or additional charge within it. We will certainly be looking at those fees and the variation of those fees as we move forward.

Deputy L.M.C. Doublet:

Okay, thank you. What steps are being taken to ensure that both clinical and administrative staff are trained to deliver care in line with best practice and gender-sensitive, trauma-informed principles when women are accessing terminations?

Assistant Minister for Health and Social Services:

I think it is technical, but we would have thought that any treatment that any person receives in our healthcare system is kind, compassionate, safe.

Deputy L.M.C. Doublet:

Is there a trauma-informed approach to care in this area? Can any of the …

Consultant Gynaecologist:

If you look at the U.K., where I came from in Oxford, the vast majority of termination services are not carried out by the principal hospital; they are outsourced to B.P.A.S. (British Pregnancy Advisory Service). That comes from the fact that when you are employing juniors or senior colleagues, you cannot ask directly: "Will you carry out a termination of pregnancy?" They have the right then to object on a …

The Minister for Health and Social Services:

Conscience.

Consultant Gynaecologist:

Yes, that they do not do it. So, extremely difficult and challenging for any service, especially here where you are on an Island, to actually maintain that service. It then does depend upon a number of individuals, which there is an onus on. But that also affords an opportunity in that it is the same people doing it all the time, so you have got actually a lower cohort to train and ensure that they are giving that service.

Deputy L.M.C. Doublet:

Okay. Minister, would you seek to investigate whether services in this area are trauma-informed and get back to us?

The Minister for Health and Social Services:
Yes.

Deputy L.M.C. Doublet:
Thank you.

Deputy J. Renouf:
Can I just move on to menopause support? We are aware that the Listening Lounge has been offering 6 free weekly sessions for women to discuss their experiences with menopause. Can you give any feedback about how those are going?

Consultant Gynaecologist:
The Listening Lounge, I am not aware of. I lead the secondary level menopause clinic in Jersey. Again, about 20 per cent of women will not respond to H.R.T. - just through physiology they do not respond - but there are other options and that is what we would tend to see in the menopause clinic. Again, no waiting time for that; it is 4 weeks maximum and they can be seen. The psychological and physical changes that happen in the menopause are quite profound. There is no doubt that women experience significant distress in that menopause, especially even around mental health issues. If there are underlying mental health issues, those are exacerbated at the menopause because it is a change in the neurophysiology that happens. We do need to have a support mechanism; our primary care colleagues look after it extremely well, and then we have a tertiary level that is available. The specific feedback from Listening Lounge, I am not aware of.

Assistant Minister for Health and Social Services:
We could try to find out.

Deputy J. Renouf:
I think to move it on, are there plans to set up any specific Jersey support services similar to the U.K. initiatives such as Menopause Matters or the British Menopause Society?

Consultant Gynaecologist:
The British Menopause Society, I have been a member of, so I know all of that. Part of it is actually informing, getting information down to patients. One thing the Minister mentioned earlier was about digitalisation. Through the N.H.S. app in the U.K., we can push information to selected individuals so you can actually: “Here, read about the menopause. Here is something about it.” So, getting that across to women, understanding what support there is. Because it is complex; it is not just the hot flushes or the mood swings, but there are numerous other physiological changes.

Deputy J. Renouf:

I guess what I am trying to get at is: are you comfortable with what we have got? Or do you think more needs to be done?

Consultant Gynaecologist:

We should never be comfortable with what you have. There is always room for improvement. We always need to improve in the service. We always need to improve communication and we always need to update the information that is there.

Deputy L.M.C. Doublet:

Is it true that there is no menopause specialist in the gynaecology …

Consultant Gynaecologist:

Sorry, I am also specially trained in the menopause.

Deputy L.M.C. Doublet:

So not true then?

Consultant Gynaecologist:

That is not true. There is no doubt about that.

Deputy L.M.C. Doublet:

In terms of your expertise then, how do women access that?

Consultant Gynaecologist:

Again, that is a 4-week waiting time. They can be referred through primary care or through my colleagues, who have got failure to treat effectively in secondary care, I am very happy to see them, again, immediately.

Deputy L.M.C. Doublet:

Can women self-refer?

Consultant Gynaecologist:

They can self-refer, but they should go through that … because I am a limited resource, as such, so you want to make sure that actually: "Have you tried H.R.T.? Have you tried the standard approach?" It is only when you get treatment failure that they should come to that level. There are

very clear guidelines through the British Menopause Society, very clear pathways that we have actually pushed out to primary care.

Deputy L.M.C. Doublet:
Thank you. Just to reflect on … some of the submissions we had were of the view that there was not enough specialist care. If there is specialist care …

Consultant Gynaecologist:
A 4-week waiting time.

Deputy L.M.C. Doublet:
… yes, how could we ensure that this information is being disseminated to women so they know it is there?

Assistant Minister for Health and Social Services:
I think it is a communication thing as well, but we have got some very good champions in the community who have really raised the profile - who have been doing great work - and we have had the brought-over specialists over here, and we have also got the G.P.s. Lots of them are doing extra training in menopause and there is a menopause support network for all government staff. I am hopeful that the stigma around menopause, the taboo, is being broken, because it is really serious. I think in the workplace you can now ask if you can have ... be in a place you can express that you are going through the menopause. If you cannot talk about it, there is a special form that you can fill in and you can ask for a cooler place, different clothing, time off.

Deputy L.M.C. Doublet:
Thank you. All of this information, where is that available for women to access?

[13:45]

Assistant Minister for Health and Social Services:
That is part of what I have discussed, because it is not out there; it is not widely known. Every woman is going to go through the menopause at some stage and some people just sail through it; other people have a really rough time; and then in between you have got all sorts. But it is also a case about living well and - probably that Daniella could say - eating the right things, exercising, getting off the bus, running, walking the last bit, taking the stairs.

Deputy L.M.C. Doublet:

Thank you. And in terms of the work that you are doing to improve the communication around this, what is your timescale for achieving that?

Assistant Minister for Health and Social Services:
I am so sorry, I cannot say, but it is something … I am so sorry.

Deputy L.M.C. Doublet:
Will it be completed by the end of this political term?

Assistant Minister for Health and Social Services:
Yes.

Deputy L.M.C. Doublet:
Okay, thank you.

Consultant Gynaecologist:
Now, a very important part of that is actually premature menopause, which is even much more complicated. It has fertility issues around it; it has got perception. That can be at the age of 15, 16. Some of the girls that I am seeing are through menopause at that age and they have got their whole life in front of them. But again, we have a specialised clinic for that.

Deputy L.M.C. Doublet:
Thank you.

The Minister for Health and Social Services:
Communication is an ongoing issue that really needs improvement consistently. I am very much hoping that the digitalisation process … once you have got everybody walking around with their medical records on their phone and you can message people with all of their health requirements and all the options available, a full digitalised system over the 5 years is going to make a big difference in communication.

Deputy L.M.C. Doublet:
Sounds good. Thank you. I wonder if I could just very quickly ask the Minister, perhaps slightly uncomfortable considering that Enda is sat in front of me, but we have heard today that a lot of things are falling to one consultant in the area of women's health. It is great to have that expert knowledge but what resilience is in place to ensure that should that consultant have other personal plans, which he is fully entitled to, or he decides to take a holiday given he might need a break, what resilience is around that system, so we are not just relying on one person?

Consultant Anaesthetist:

I can just take part of this, is that we have had reliance on locum consultants. We have now substantiated so we have a full workforce of consultants, and we are increasing our … it is called staff grade and associate specialist doctors which is a sort of … I will not say junior doctors because we do not call them that anymore but those that are not consultants, so expanding their numbers as well to give them specialist training so that they can then be empowered to take over Enda's clinic when he is not here and things like that. We are doing a massive piece of work. We have got 3 new consultants that we interviewed last week, and they have all taken the role. They will start in about July. We have got certain areas that they will have as expertise. We have got a gynaecological consultant who is going to take on a lot of the women's health. We have already got a new gynaecological lead who is also leading on the Early Pregnancy Assessment Unit. We have got a urogynaecological specialist, which is an area which is really difficult to recruit to. We have got an amazing guy starting and then we have got a lead for labour ward who will be taking on foetal medicine and maternal medicine. It is something that we really care about. Then also employing specialist nurses and other people who can take on a lot of these roles, but you are right, the one thing I picked up today is that dissemination of information.

Deputy L.M.C. Doublet:

Thank you and, again, it is really positive to hear of those developments.

The Minister for Health and Social Services:

Safe to safe and I think you will bear me out, we stopped from quite a long way back from having had a lot of locums in place. We talk about resilience but the first thing you need is permanent consultants, and a lot of progress has been in a lot of areas on recruitment so well done to the team. They have really made a huge effort. You can then build in the further resilience once you have got the permanent people in place.

Deputy L.K.F. Stephenson:

Great. Thank you very much. To move on to the maternity unit improvement plan. As of January, I think, last year, we had 87 out of the 127 recommendations from the improvement plan that had been completed. Can you provide an update on where we are at currently with how many have been completed and any other significant milestones to do with that, please?

Deputy L.M.C. Doublet:

Can I just do a time check as well? We have got 2 more sections to get through and only 10 minutes so speed up once more.

Director of Midwifery and Nursing for Women and Children:

Okay, I will be as quick as I can. I think the Maternity Improvement Panel obviously was 127 recommendations. Of them know we have only got one of those that are not business as usual and I will go into in a minute. Obviously, every single one of the other 126 have gone through the 30, 60, 90, 120-day reviews to make sure that they are business as usual, and now that is our baseline of where we make sure that we audit that as regularly as possible to make sure that that is how we are improving. The one that is not closed yet is the culture and I think that that is because it is a big issue. It is not something that can be resolved overnight so it is something we have not closed yet because we want to make sure that … we have introduced our time to chats, we have weekly M.D.T. meetings, which are very much an M.D.T. approach. We have all had psychological safety in the workplace training, and we have done that as an M.D.T. approach as well. We have obviously improved the communication across the unit threefold and we have daily safety huddles at 3 points throughout the day. I think we are still on that journey with the culture, so we do not want to change that. I think one of the biggest things we have got obviously with our new consultants happening, but we have now got no agency midwives within our workforce either because we have been able to make either some of them substantive or we have had other midwives who have come from the United Kingdom to work with us as well and they have taken up substantive roles. That is something that we are very proud of now, not to have any agency, so I think now we have a very strong workforce that is permanent. It is one of the real things that will help us to be able to close that cultural thing, but we absolutely do not want to close it until we know that we have gone through everything possible on that journey for culture.

Deputy L.K.F. Stephenson:

Thank you. Have there been any measurable changes in rates of interventions, for example, since the improvement plan was introduced, and if you have got any feedback about how the refurbishment of the unit has also helped patient experience?

Director of Midwifery and Nursing for Women and Children:

Obviously, patients' experience is something that we do take, and we do ask anybody who uses our facilities what they use. We have had an awful lot of feedback in relation to the birthing pools that we have now got that are permanent. We have also got a room that they can use for an early labour or for their induction of labour, so we absolutely have made some really great changes. We have got tours of the unit now as well so that women can come and look around. We work very closely with Baby Steps, which is who provides all of our women with their antenatal education. They now do a tour within the unit as one of their labour talks making it very interactive, so when they do come into the unit they are seeing what our rooms look like and what the environment looks like. I think there has been a lot of positive feedback on the refurbishment. We have also uploaded the new tour of the unit on to our website. We are very much looking at the whole of the maternity website

and information, and that has all been updated from the physio stuff that we do in relation to any of the counselling or anything that we are able to offer them or debrief service. That is all being updated at the moment.

Deputy L.K.F. Stephenson:
As far as interventions go, is there any data to show any changes there?

Director of Midwifery and Nursing for Women and Children:
One of the biggest ones would be our blood losses after they have had babies. We had a very, very big proactive check last year; the number of massive obstetric haemorrhages was quite excessive in 2023. We then looked at that and we have made a massive 50 per cent decrease within that and that has been an awful lot of education, an awful lot of learning, an awful lot of stuff that we have had our practice development involved in, our risk midwife involved in and that is something we are very proud of. We have done that audit and that audit on goes every day, that anybody who does have any blood loss we review it on a regular basis so that we can make sure, if there is any learning, we embed that in practice.

Deputy L.M.C. Doublet:
Can I just clarify, so you mentioned that 126 of the recommendations are business as usual. Does that mean they have been achieved?

Director of Midwifery and Nursing for Women and Children:
Yes, that means they have been achieved. They have been through the cycle of the 30, 60, 90, 120 days. So they have had that 4-month review as well to make sure that they have been embedded as business as usual as well.

Deputy L.M.C. Doublet:
That is something to really be celebrated, is it not, so thank you for sharing that with us? In terms of breastfeeding, the births and breastfeeding report states that around only 23 per cent of mothers aged 24 and under were still breastfeeding at 6 to 8 weeks. Is any work underway to establish what differing needs, what different groups of women might need in terms of breastfeeding support?

Director of Midwifery and Nursing for Women and Children:
We are very lucky that we have got an infant feeding support midwife in place, which we are very proud of. They work very collaboratively alongside our, obviously, Family Nurse Partnership as well. They have achieved level 2 B.F.I. (Baby Friendly Initiative) within the hospital and level 3 within the community recently as well, so there is an awful lot of work that we are doing. We do monthly audits on that as well to make sure that all of our staff are educated. Our infant feeding specialist runs a

2-day workshop that all staff, as soon as they join the organisation, undertake so that we are giving a consistent message about feeding so that we get the people off to the best start.

Deputy L.M.C. Doublet:
Thank you, and very briefly, could you outline what might be needed in terms of breastfeeding support to reach that optimal level?

Director of Midwifery and Nursing for Women and Children:
I think that is just about having breastfeeding champions and I would say that that is something we are very much working on as well. We have got an M.S.W. (maternity support worker) now that is in breastfeeding and works very much alongside our infant feeding midwife, and I think that we are just strengthening those. Our infant feeding specialist is also doing additional training to become a lactations consultant and I think that will really strengthen our knowledge and skills within our workforce.

Deputy L.M.C. Doublet:
Okay. Thank you very much. We have some miscellaneous questions now about health conditions affecting women. I would like to ask about osteoporosis. Women have a much higher risk of developing osteoporosis, are 3 times more likely to break a bone before being diagnosed with osteoporosis. Can you, Minister, provide an update on the status of the waiting list for a DEXA bone density scan which in July 2024 stood at 400 patients on that waiting list.

The Minister for Health and Social Services:
It may not surprise you but I cannot. I am not sure we have anybody here for that.

Assistant Minister for Health and Social Services:
We may have to come back to you from the …

Deputy L.M.C. Doublet:
Okay, yes, if you could come back to us.

Assistant Minister for Health and Social Services:
I mean I know how important it is, though, and sometimes if you have H.R.T. for your menopause then you are perhaps protected better but also you need to exercise and eat all the right things.

Deputy L.M.C. Doublet:
Thank you. I think we will probably follow that one up at the next hearing.

The Minister for Health and Social Services:
I hope all your miscellaneous questions are not this difficult.

Deputy L.M.C. Doublet:
Post-natal physiotherapy, I think, we discussed this at a previous hearing, can you advise if there is routine post-natal physiotherapy support?

Director of Midwifery and Nursing for Women and Children:
This is an area that we have really strengthened recently, and we are working very much with our physiotherapy team, and they are going to have on their website as well all the information so that women can access it immediately and how they can access that service. Yes, it is definitely something we have strengthened.

Deputy L.M.C. Doublet:
Thank you. Will our service be comparable to countries like France where women are offered a number of sessions, and every woman is offered that routinely?

Director of Midwifery and Nursing for Women and Children:
Any woman who would like to have that. I would say that that is some of our work with our new consultants as well that we are taking on board and I think they will be working alongside so it will be very much an M.D.T. approach as well.

Deputy L.M.C. Doublet:
Okay. Thank you. Minister, will you ensure as well that this information about these new services is widely made available to women?

Assistant Minister for Health and Social Services:
Yes, I am aware that it is a real area that we need to address.

Deputy L.M.C. Doublet:
Thank you. Another miscellaneous area, so we have become aware of a study that found that auto-immune diseases affect 13 per cent of women versus 7 per cent of men so indicating women are twice as likely to be diagnosed with an auto-immune condition. There is currently no published data that we could find on the prevalence for auto-immune diseases disaggregated by gender in data unless your public health colleague … Minister, would you commit to investigating …

The Minister for Health and Social Services:
Yes, very happy to commit to investigating. I have not taken any medical training.

Deputy L.M.C. Doublet:

Thank you. We look forward to hearing. Do you have any miscellaneous … anything that is miscellaneous? Okay. Thank you. Just to end the hearing, I wanted to thank the Ministers and the Ministerial team. It has been really interesting hearing about some of the recent improvements. I think there have been lots of positive developments that you have shared with us today around the breast screening, around the maternity improvements and certainly in the increase in staff in the Obstetrics and Gynaecology Department that I think women in Jersey will be heartened to hear of the attention that is being paid to those issues. I was also heartened to hear, Minister, that you accept the findings of the report, and there are several areas that you have committed to coming back to the panel. So we look forward to hearing more information on those areas. For members of the public who are interested in following developments in the women's health sphere, we will be writing to the Minister to prompt some of those updates. You will be able to view those letters. They will be made public on the Scrutiny website, so if you just Google "Scrutiny Jersey Health Panel", you will be able to find our page and see all of the correspondence in this area. As I said at the beginning, please do fill in your feedback cards and let us know whether you found this to be beneficial today and any other improvements that you would like to see either in the way Scrutiny operates or any areas of women's health or any areas of Health or Social Security that you would like the panel to look into. As the Minister said, we are also always available on our emails to receive any feedback from the public. I am going to ask if my panel wanted to add anything final before we wrap up?

Deputy J. Renouf:

I would just reiterate the point about being open to hear from members of the public. We take a lot of leads from the public when people get in touch with us. It is very, very helpful to hear from the public and we enjoy that part of our work.

[14:00]

Deputy L.K.F. Stephenson:

Me too, and I suppose I would then just add that I think, as we have heard today, a lot of the discussions have come from things that have been raised by members of the public either putting experiences on social media that have prompted questions or actions by the department, emails to the Minister, emails to Scrutiny. I think we all, as a community, have a part to play in the discussions around women's health, breaking down some of the stigmas we have talked about. It is not just about the department putting the information online. It is about all of us talking about it, as well as many people in the audience know, so thank you for all that many of you have done as well and let us keep talking about it.

Deputy L.M.C. Doublet:
Minister, would you like to add anything before we close the hearing?

The Minister for Health and Social Services:
Yes, I do not want to keep people but in the first instance I would like to thank you. This is all rather daunting because it is a much bigger audience than usual, but thank you for doing that because it has given us a chance to hopefully display where we are going. I would like to thank the people that have taken the time to turn up today. I realise that we are far from perfect. There is a long way to go. I think it is going to take 5 years up to the opening of the new hospital until we get things really, really humming. What I hope you have seen today is there is a team of really, really good people working exceptionally hard to make things better and people that are taking women's health extremely seriously. If you take nothing else away from this, at least you know that there are some very, very professional, very hardworking people working on your behalf, so I thank the team. **(Applause)**

Assistant Minister for Health and Social Services:
We, as the Ministerial team, are also very … do get in touch with us if you feel that we can do anything.

The Minister for Health and Social Services:
I forgot a special thank you.

Deputy L.M.C. Doublet:
Thank you, and I will close the hearing with a message for the women of Jersey that please continue speaking up, please continue supporting each other and advocating for your health needs and for each other's health needs and to expect the highest quality health outcomes and health services. Yes, keep talking to us and thank you everybody for attending today. I will close the hearing now.

[14.01]